NORTHEAST DELTA DENTAL PO Box 2002 Concord, New Hampshire 03302-2002 1-800-537-1715

DELTAPREFERRED OPTION® PLEASE PRINT OR TYPE-IN BLUE OR BLACK INK ONLY.

DELTA DENTAL PLAN OF MAINE

Mail completed form to: Employee Health & Benefits 114 State House Station Augusta, Maine 04333-0114

● EMPLOYEE INFORMATION						
LAST NAME	FIRST NAME	(8 CHARACTERS ONLY		BIRTHDATE	MO DAY Y	/EAR
SOCIAL SECURITY# SE	X	MARITA	AL STAT	us		
_ - -	☐ F SINGLE ☐ MARRIED	DIVORCED	LEGA	LLY SEPARATED	☐ WIDO	WED
ADDRESS	CITY			STATE	ZIP	
TELEPHONE# ()	DATEOFHIRE		DATE	OFREHIRE		
EMPLOYERNAME	ADDF	RESS				
GROUP NUMBER	SUBLOCATION NUMBER	SUBLOCATION NUMBER		EFFECTIVE DATE		
❷ REASON FOR APPLICATION (CHECK APP	PROPRIATE BOXES) ☐ ADD	DELETE				
NEW ANNUAL OPEN ENROLLMENT CHANGE OF NAME/ADDRESS IMPORTANT! If your spouse works for The State of Maine or its Ancillary agencies, he or she is NOT eligible for coverage under your policy. Dual Dental Coverage is not allowed for State of Maine Employees.	SPOUSE'S EMPLOYMENT NOLONGER DEPENDENT	T CHANGE FOR I.R.S. PURPOSE		THER		
NOTE : IF ENROLLING ONE ELIGIBLE D 19 PLEASE INDICATE NEXT TO N	EPENDENT, ALL MUST BE E IAME IF DEPENDENT IS A ST	ENROLLED. IF ENR FUDENT OR INCAP	OLLING ACITATE	DEPENDENT CH ED.	HILDREN O	VER
③ DEPENDENTINFORMATION NOTE: LIS	T ONLY DEPENDENTS FOR	WHOM CHANGE	OF STA	TUS IS REQUES	TED	
LASTNAME FIR	ST	INITIAL	SEX	BIRTHDATE	RELATIO	NSHIP
O TYPE OF COVER AGE (DI FACE CUECK ON						
TYPE OF COVERAGE (PLEASE CHECK ON			_			
□ 1-EMPLOYEE ONLY□ 2-EMPLOYEE & SPOUSE / DOMESTIC PART□ 3-EMPLOYEE, SPOUSE / DOMESTIC PART	TNER	5-EMPLOYEE & CHIL 6-EMPLOYEE & CHIL				
⑤ PREVIOUS/EXISTING COVERAGE						
WILL THIS DENTAL COVERAGE REPLACE AN					□ NO	
WILL YOU OR ANY OF YOUR FAMILY MEMBE					□ YES	□ NO
IF YES, NAME OF THE INSURER		POLIC	YNO.			
EFFECTIVE DATE OF PLAN	.□ SINGLE □ TWO	PERSON	FAMIL'	Y		
THIS INFORMATION IS REQUIRED SO THAT DELTA M.	AY COORDINATE BENEFITS WITH T	THE OTHER CARRIER S	OY TAHT C	DU MAY BENEFIT FR	OM DUAL CO	VERAGE.
G I CERTIFY THAT ALL INFORMATION IS TRUE AN PROVIDER FOR MYSELF OR ANY FAMILY MEMBER EFFECTIVE DATE AND TERMINATION DATE OF MY MUNDERWRITING GUIDELINES OF NORTHEAST DEL'COVERAGE, I AUTHORIZE THE DEDUCTIONS OF THE ANY DENTAL PREMIUM WHICH EMPLOYEE HEALT UNDERSTAND THAT MY DEPENDENTS MUST REMAFAMILY STATUS CHANGE.	, I WILL BE RESPONSIBLE FOR MEMBERSHIP WILL BE DETERMIN TA DENTAL. IF MY EMPLOYER (SE AMOUNTS FROM MY WAGES). HAND BENEFITS CERTIFIES IS AND BENEFITS OF THE SENTE OF T	HIGHER OUT-OF-POC NED BY MY EMPLOYE DR PLAN SPONSOR F I FURTHER AUTHOR S OWED BY ME AS O D ONLY DURING CON	KET EXP R OR PLA REQUIRES ZE MY EN DF THE I TRACT R	ENSES. I ALSO UN IN SPONSOR IN AC B EMPLOYER CON IPLOYER OR PLAN DATE MY APPLICA EOPENING, EXCER	NDERSTAND CCORDANCE TRIBUTIONS SPONSOR T ATION IS API PT IN THE EV	THAT THE WITH THE FOR THIS O DEDUCT PROVED. I /ENT OF A
SIGNATURE						
ELECTION NOT TO ENROLL (ALLOWED FOR EMPLO NOT WISH TO ENROLL AND UNDERSTAND THE OPP MAINE GROUP POLICY.						

SIGNATURE _

DATE